

into the descending loop a fillet of silk with a shot attached to one end, the free end being held out on the abdomen. The peristalsis of the bowel expels the shot with silk attached to it. To the free end of the silk fillet larger and larger bougies are successively attached and guided into the stricture by traction on the thread at the anus. When dilatation of the stricture has proceeded so far that passing of bougies from the anus is feasible, attempts at retrograde dilatation are no longer persisted in.

The advantages of this procedure are the avoidance of false passages, the practicability of leaving the bougie longer in the grasp of the stenosis, thereby hastening dilatation.

In one of the instances where the above procedure failed to effect a permanent cure, the method of intestinal exclusion was resorted to. The sigmoid flexure was made to anastomose with the rectum below the level of the stenosis. The anastomosis was done with the Murphy button, but the orifice between the rectum and sigmoid subsequently contracted, but was much easier of dilatation by the introduction of the finger from the anus.—*Beiträge zur klinischen Chirurgie*, Band xxxi, Heft 3.

MARTIN W. WARE (New York).

## EXTREMITIES.

**I. A New Method of Reducing Dislocations of the Shoulder.** By DR. F. HOFMEISTER (Tübingen). The principle of this method consists in the application of a systematic permanent extension of the upper extremity by weights. The incentive to this procedure emanated from Stimson's plan to place the patient in a hammock and allow the arm to pass through a hole in the hammock, and by attaching weights, eight to twelve pounds, to the dependent arm, a reduction is accomplished within four to six minutes. The author finds this method efficient, yet enumerates as drawbacks the great pressure exerted on the axilla by the hole in the hammock, which tends to increase the venous stasis favored so strongly by the dependent position of the arm. Both

of these factors tend to make this method painful, and, finally, a bulky apparatus (?) operates against a general use of this method of Stimson. These disadvantages the author claims to have offset by his method. The patient is comfortably placed on his sound side. Extension straps are then applied to the arm of the affected side, as high up as the deltoid insertion, and secured with a roller bandage tightly applied, to prevent sliding of soft parts on the bone. A rope, connected with the straps, is guided over a set of pulleys attached to the end of a rod. The rod is raised to a sufficient height to permit of full extension of the arm. Ten pounds are first fastened to the free end of the cord, and at intervals of five minutes additional ten pounds are added until forty pounds are reached. Five to fifteen minutes' action of this force suffices to effect a reduction, which may set in sooner sometimes. Once the reduction set in after two minutes. A dislocation of two weeks' standing was reduced with forty pounds weight in forty-five minutes. In four instances reduction was hastened, as soon as the head of humerus was on margin of the glenoid, by drawing the head towards the acromion process, removal of the weights, and slowly adducting the arm. The latter procedure is eminently proper even after perfect reduction, since bringing the arm from complete extension to the side of the chest in careless fashion may result in a dislocation. Seven times this method was employed in each instance successfully. The constant moderate traction of the weights overcomes the contraction of the muscles. The avoidance of a narcosis, the relative simplicity (?) of the technique, and its absolute harmlessness are advantages which may make this method more popular among practitioners than the manipulative procedures of Kocher.—*Beiträge zur klinischen Chirurgie*, Band xxx, Heft 2.

**II. Congenital Dislocation of the Scapula.** By DR. WILHELM RAGER (Copenhagen). The preliminary remarks cover the author's narrative of three cases. Two of the cases showed other congenital defects: congenital hernia and adenoid vegeta-

tions. Aside from the dislocation, there were found alterations of the scapula in both instances and defective formation of the upper dorsal vertebrae (X-ray); in both instances there is a neurotic family taint. All these factors contribute to a neurotic basis (defect) of this deformity. Together with his own cases and including the four original cases of Sprengel, the author has collected thirty unilateral and two bilateral cases. The left scapula is most frequently affected, sixteen times, the right eight. The analysis tends to show that the cases are not all of the same class, wherefore the following classification is offered:

Group I embraces cases with a change of axis of scapula, prominence of superior angle of scapula in supraclavicular fossa, with ligamentous or cartilaginous union with the spine; scoliosis of slight degree.

Group II has no instances of deviation of axis of scapula, but all other features.

Group III comprises instances of marked bony deformities extending from the atlas to the scapula.

Group IV refers to dislocations of scapula towards or from median line with associated trophic disturbances.

Etiologically, all the factors that have been credited to congenital dislocation of the hip are also held responsible for this. Prognosis is bad as far as cure of deformity is concerned, but the elevation of the scapula does not become aggravated with growth.

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